Pure Resolutions LLC

An Independent Review Organization

Phone Number:
(817) 779-3288

990 Hwy. 287 N. Suite 106 PMB 133
Mansfield, TX 76063
Email:pureresolutions@irosolutions.com

Fax Number:
(817) 385-9613

Notice of Independent Review Decision

Case Number

Date of Notice: 06/27/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopaedic Surgery

Description of the service or services in dispute:

Inpatient surgery for Open 360 Fusion L3-S1 with a LOS of 2 days

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male who was involved in a motor vehicle accident on XX/XX/XX. His diagnoses include lumbar spondylosis, displacement of lumbar intervertebral disc without myelopathy, spinal stenosis of the lumbar region, and low back pain. Past treatments were noted to include physical therapy, injections, and diagnostic studies. The patient underwent a lumbar MRI on XX/XX/XX, which documented a superiorly extruded disc herniation at L3-4 ranging from 5 to 7 mm producing impression on the bilateral L3-4 nerve roots; broad based disc herniation at the L4-5 with impression on the bilateral L4 nerve roots in the neural foramen; and a broad based superiorly extruded disc herniation at the L5-S1 producing moderate compression of the bilateral L5 and S1 nerve roots. On XX/XX/XX the patient complained of right lower back pain rated 6/10. The patient reported that physical therapy did not help in XXXX and previous back injections also helped slightly. Medications included allopurinol, dorzolamide, fosinopril, latanoprost, sertraline, and triamterene/hydrochlorothiazide. Social history noted the patient was a former smoker who was not currently smoking or chewing tobacco. The patient has a medical history for anxiety, depression, diabetes, hypertension, and kidney disease. The physical examination of the lumbar spine revealed no tenderness at the spinous process, transverse process, sacral promontory, sacrum, or coccyx. There was also no tenderness noted at the bilateral hips or SI joints. It was documented there was tenderness at the supraspinous ligament and paraspinal region at the L5. Range of motion was noted to be painful; however, normal. Motor strength was noted to be normal except at the right ankle dorsiflexion tibialis anterior, great toe extension, extensor hallucis longus on the right and plantarflexion gastrocnemius on the left. The patient had decreased sensation to the right lateral leg, dorsum of the foot, and sole of the foot at the L5-S1 dermatomes. The request was previously reviewed on XX/XX/XX. The request for inpatient surgery for open 360 fusion at the L3-S1 with length of stay of 2 days was previously denied due to criteria for a fusion has not been met and MRI does not document significant facet pathology. A progress note dated XX/XX/XX, documented the patient presented for a follow-up examination. The patient was reported to be better than from previous exam. The patient complained of low back pain, right leg, right shoulder, and neck pain. The physical; examination of the lumbar spine revealed decreased reflexes at the right Achilles. Lower extremity strength was noted at 5/5. The right hip flexor was noted to be decreased with spasms at the paraspinals. The patient was not equally weight

bearing as he stands with most of weight on the left due to increased pain at the L5-S1. The treatment plan included appealing the surgery and performing a home exercise program as tolerated.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

According to the Official Disability Guidelines, a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiological evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Fusions may also be indicated after at least two failed discectomies or for revision surgery with evidence of imaging confirmation of pseudoarthrosis and/or hardware breakage/malposition; and when significant functional gains are reasonably expected. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Patients should also undergo a complete psychological assessment to rule out any barriers to surgical success. Patients undergoing posterior and anterior lumbar fusions are allotted a median of 3 days inpatient stay.

A request was received for inpatient surgery for open 360 fusion at the L3-S1 with LOS of 2 days. The patient was noted to have chronic low back pain and nerve root compromise from the L1-S1 upon MRI. However, there was lack of clinical evidence submitted for review indicating the patient had significant spondylosis with instability, corroborated radiculopathy, or spinal stenosis. There was also lack of documentation indicating the patient had a spinal fracture, dislocation, or has failed previous discectomies to warrant a posterior and anterior lumbar fusion at this time. Moreover, there was a lack of a complete psychological assessment ruling out barriers to surgical success submitted for review. Based on the above, the denial for request of inpatient surgery for open 360 fusion l30-S1 with LOS of 2 days is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)